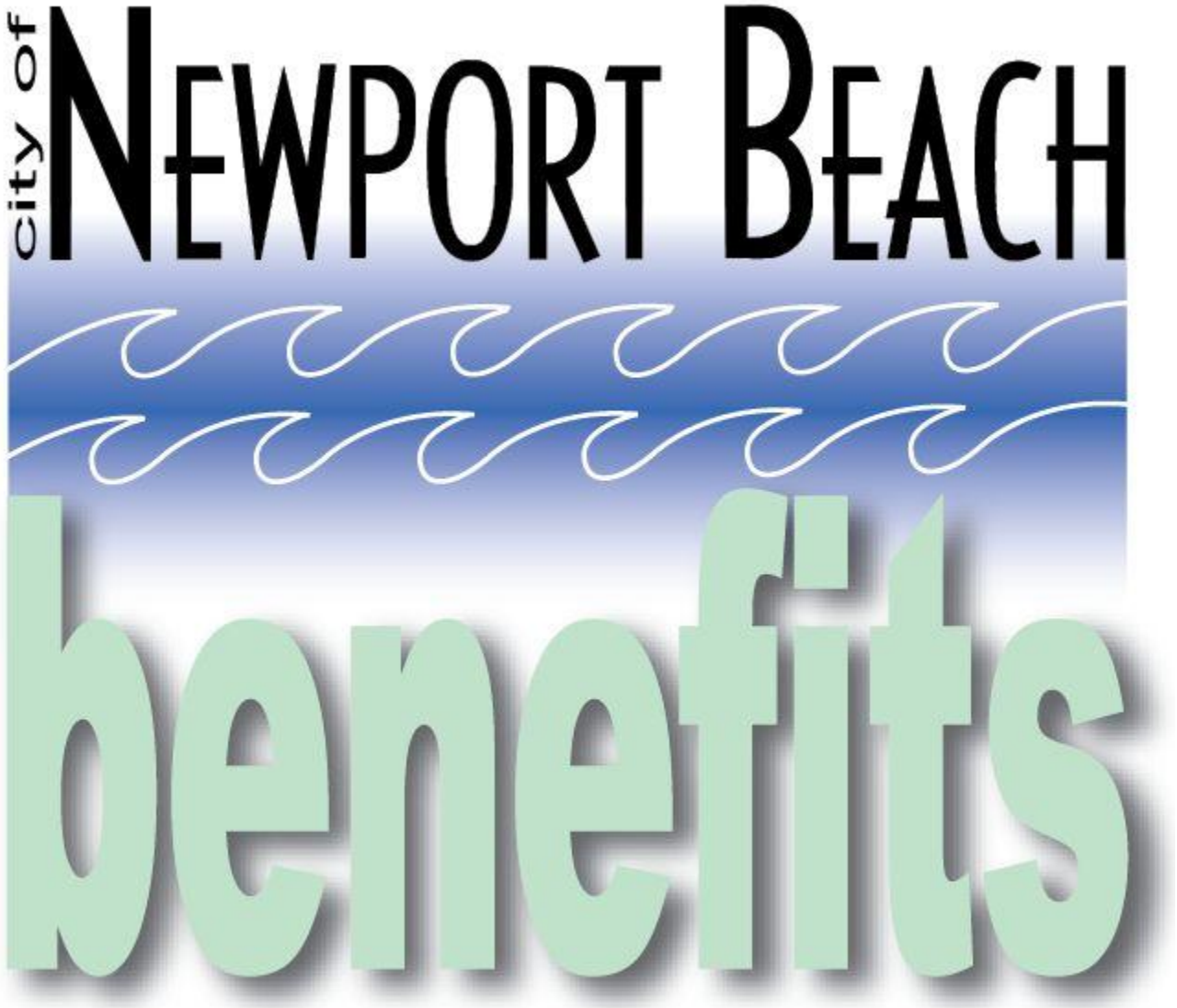

- **Medical Plan Comparison Chart**
- **Dental Plan Comparison Chart**
- **Vision Plan Summary Chart**

ACTIVE

2013

Medical Plans Comparison Chart

Coverage Details	CalPERS Blue Shield Net Value HMO	CalPERS Kaiser HMO	CalPERS Select PPO / CalPERS PERSChoice PPO *		CalPERS PERSCare PPO *		CalPERS PORAC PPO *	
	CalPERS Blue Shield HMO		*In-Network*	*Out-Of-Network*	*In-Network*	*Out-Of-Network*	*In-Network*	*Out-Of-Network*
Calendar Year Deductible	None	None	$500 individual $1,000 family (combined)		$500 individual $1,000 family (combined)		$300 individual $900 family	$600 individual $1,800 family
Out-Of-Pocket Maximum	$1,500 individual $3,000 family	$1,500 individual $3,000 family	$3,000 individual $6,000 family	None	$2,000 individual $4,000 family	None	$3,000 individual $6,000 family	
Physician Office Visits	$15 co-pay/visit	$15 co-pay/visit	$20 co-pay/visit	You pay 40%	$20 co-pay/visit	You pay 40%	$20 co-pay/visit (deductible does not apply)	You pay 10%
Diagnostic Lab & X-Ray	No charge	Some procedures may require a co-pay	You pay 20%	You pay 40%	You pay 10%	You pay 40%	You pay 10%	You pay 10% (varies)
Annual Physical Exams	No charge	No charge	No charge	You pay 40%	No charge	You pay 40%	No charge; $500 max/cal. yr. (combined)	
Well Baby Care	No charge	No charge	No charge	You pay 40%	No charge	You pay 40%	No charge; $500 max/cal. yr. (combined)	
Emergency Room Urgent Care Non-Emergency	$50 co-pay/visit; waived if admitted $15 $50 co-pay/visit; waived if admitted	$50 co-pay/visit; waived if admitted $15 $50 co-pay/visit; waived if admitted	You pay 20% after $50 deductible; waived if admitted $20 $20	You pay 20% after $50 deductible; waived if admitted 40% 40%	You pay 10% after $50 deductible; waived if admitted $20 10%	You pay 10% after $50 deductible; waived if admitted 40% 40%	You pay 10% 50% 50%	
Hospital Services	No charge	No charge	You pay 20% 20%-30% (PERS select only)	You pay 40%	You pay 10% ($250/ admission inpatient facility deductible)	You pay 40% ($250/ admission inpatient facility deductible)	You pay 10%	You pay 10% (varies)
Chiropractic	Not covered *Call carrier for possible discounts	Not Covered *Call carrier for possible discounts	You pay 20%; up to 15 visits/cal. yr. *(combined w/out-of-network)*	You pay 40%; up to 15 visits/cal. yr. *(combined w/in-network)*	You pay 10%; up to 20 visits/cal. yr. *(combined w/out-of-network)*	You pay 40%; up to 20 visits/cal. yr. *(combined w/in-network)*	Up to 20 visits/calendar year	$35 per visit
Hearing Aids Exams Materials	No charge $1,000 max/36 months	No charge $1,000 max/36 months	You pay 20% You pay 20% *1 hearing device every 36 months*	You pay 40% You pay 40% *1 hearing device every 36 months*	You pay 10% You pay 10% *1 hearing device every 36 months*	You pay 40% You pay 40% *1 hearing device every 36 months*	You pay 20% You pay 20% *No deductible; one hearing aid per ear every 36 months*	You pay 20% You pay 20% *No deductible; one hearing aid per ear every 36 months)*
Prescription Generic Brand Non-formulary	*30-day supply 4* $5 co-pay $20 co-pay $50 co-pay	*30-day supply* $5 co-pay $20 co-pay N/A	*30-day supply [1,2,3]* $5 co-pay $20 co-pay $50 co-pay	*30-day supply [1,2,3]* $5 co-pay $20 co-pay $50 co-pay	*34-day supply [1,2,3]* $5 co-pay $20 co-pay $50 co-pay	*34-day supply [1,2,3]* $5 co-pay $20 co-pay $50 cop-ay	*34-day supply or 100/pills units, whichever is more* $10 co-pay $25 co-pay $45 co-pay Compound: $45	*34-day supply or 100/pills units, whichever is more* $10 co-pay $25 co-pay $45 co-pay Compound: Not Covered (see EOC)
Mail Order Generic Brand Non-formulary	*90-day supply* $10 co-pay $40 co-pay $100 co-pay	*90 day supply* $10 co-pay $40 co-pay N/A	*90-day supply* $10 co-pay $40 co-pay $100 co-pay ($70 if medically necessary)	*90-day supply* $10 co-pay $40 co-pay $100 co-pay ($70 if medically necessary)	*90-day supply* $10 co-pay $40 co-pay $100 co-pay ($70 if medically necessary)	*90-day supply* $10 co-pay $40 co-pay $100 co-pay ($70 if medically necessary)	$20 co-pay $40 co-pay $75 co-pay (See EOC for specialty pharmacy fees)	*N/A*
Mental Health Inpatient Outpatient	No Charge No Charge (exceptions may apply)	No Charge $15/individual visit	You pay 20% You pay 20%	You pay 40% You pay 40%	You pay 10% You pay $20 per visit	You pay 40% You pay 40%	You pay 10% You pay 10%	
Substance Abuse Inpatient Outpatient	No charge No Charge (exceptions may apply)	No charge $15/individual	You pay 20% You pay 20%	You pay 40% You pay 40%	You pay 10% You pay $20 per visit	You pay 40% You pay 40%	You pay 10% You pay 10%	

*[1] Implementation of specialty & biotech drug management, education & compliance programs for the following: Asthma, Rheumatoid arthritis, Multiple sclerosis, Cancer treatment/blood modifying agents, Hepatitis C, Psoriasis & Growth hormones. Implementation of promotion of over-the-counter (OTC) drugs when available.[5] Mandatory mail service for maintenance drugs. Mail Service would be mandatory after the 2nd fill of Rx at retail pharmacy, OR Member will be charged the appropriate mail service co-pay for a one-month supply at retail. [2] Mandatory generic substitution; if a brand name is requested when generic is available you will be responsible for generic co-pay and the difference between the generic and brand name. [3] Self-administered injectable medications are available under your pharmacy benefits and are no longer payable under the medical benefit. *Administered by Blue Cross. These benefit summaries only highlight your benefits. They are not summary plan descriptions (SPDs). If any discrepancy exists between this summary and the official documents, the official documents will prevail.*

Dental Plans Comparison Chart

	Delta Dental DHMO	Delta Dental PPO	
		PPO	*Non-PPO*
Annual Deductible	None	None	$50 single / $150 family
Calendar Year Maximum Ins. Pays	None	$2,000	$2,000
Preventive Services *Exams, X-rays, diagnostic tests, prophylaxis, fluoride, sealants, space maintainers, and palliative care*	Co-pays from $0 -$50	No charge	No charge up to UCR: $50 deductible waiver
Basic Services *Fillings, endodontics, periodontics, and oral surgery*	Co-pays from $0 -$365	You pay 10%	You pay 20% of UCR
Major Services *Prosthodontic repairs, crowns, inlays, onlys, bridges, and dentures*	Co-pays from $0 -$365 (additional charges for precious metal or lab fees)	You pay 40%	You pay 50% of UCR
Waiting Period	None	None	
Orthodontia	Child (under age 20): $1,900 co-pay Adult (over age 20): $2,100 co-pay	You pay 50% of UCR: insurance pays: $2,000 lifetime maximum (Children and Adults)	

UCR – Usual, customary and reasonable charges.

Vision Plan Summary

	In-Network	*Out-Of-Network*
Exams	No charge after $10 co-pay	Up to $35 allowance.
Frames	Insurance pays up to maximum of $100 retail	Insurance pays up to maximum of $65 retail
Corrective Lenses Single Bifocal Trifocal Lenticular (single vision and multifocal)	No charge No charge No charge No charge	Up to maximum of $25 Up to maximum of $35 Up to maximum of $45 Up to maximum of $100
Medically Necessary Contact Lenses Insurance Pays	Up to maximum of $250	Up to maximum of $250
Non-Medically Necessary Contact Lenses Insurance Pays	Up to maximum of $135 (in lieu of other vision materials)	Up to maximum of $100 (in lieu of other vision materials)
Second Pair Benefit	20 % discount from in-network provider's reasonable & customary fees when purchased at the same time as 1st pair. Most expensive pair will be considered the 1st pair.[1]	Not covered

[1] Limited to prescription sunglasses, VDT prescription in lieu of bifocals, safety glasses, occupational and recreational glasses.